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Civil Service Should Audit Kaiser Plans' Premium Rates under the Federal Employees Health Benefits Program To Protect the Government. HRD-78-42; B-164562. January 23, 1978. 17 pp. + 2 appendices (5 pp.).

Report to Alan K. Campbell, Chairman, Civil Service Commission; by Gregory J. Ahart, Director, Human Resources Div.

Issue Area: Health Programs (1200); Health Programs: Reimbursement Policies and Utilization Controls (1208).
Contact: Human Resources Div.
Budget Function: Health: Health Care Services (551).
Organization Concerned: Kaiser-Permanente Medical Care Program.
Congressional Relevance: House Committee on Post Office and Civil Service; Senate Committee on Governmental Affairs: Civil Service and General Services Subcommittee.
Authority: Federal Employees Health Benefits Act of 1959 (5 U.S.C. 8901).

The Federal Employees Health Benefits (FEHB) program provided health insurance coverage for 9.5 million participants in 1976 and 9.7 million participants in 1977. The Kaiser-Permanente Medical Care Program (Kaiser) is the largest prepaid group practice program in the United States. The Federal Employees Health Benefits Act requires that rates charged under health plans' contracts shall reasonably reflect the cost of benefits provided. It is important that the Civil Service Commission (CSC) determine whether rates of the Kaiser plans of northern and southern California are reasonable since they are used to calculate the Government's contribution to the FEHB program. Findings/Conclusions: CSC has made only limited audits of the Kaiser plans and has not followed up on these audits. One reason that audits have not been comprehensive was that CSC lacked criteria for evaluating reasonableness of rates. Kaiser plans are community-rated with premium rates based on the projected health care experience of all groups expected to be enrolled in the plan, in contrast to other plans which are based only on the experience of Federal participants. The inclusion of non-Federal groups makes it more difficult to determine whether rates are reasonable for Federal employees. Some characteristics of the Kaiser plans which require evaluation for their impact on the Federal rate are: Kaiser may use excess revenues as management sees fit and increase premiums to recover losses, rates are designed to meet not only current health benefit costs but also long-term capital needs, and the plans consistently underestimated revenues that would be derived from proposed premium rates. Recommendations: CSC should: develop criteria to evaluate the reasonableness and equity of rates of community-rated, comprehensive health plans like the Kaiser plans and comprehensively audit the California Kaiser plans to determine whether their FEHB program rates reasonably reflect

the cost of providing benefits to Federal program participants. (HTW)

5104

UNITED STATES
GENERAL ACCOUNTING OFFICE

Civil Service Should Audit Kaiser Plans' Premium Rates Under The Federal Employees Health Benefits Program To Protect The Government

The Federal Employees Health Benefits Act requires that rates charged by plans participating under the act reasonably and equitably reflect the cost of benefits provided. However, the Civil Service Commission has not determined if the premium rates of the California Kaiser plans conform to these requirements.

It is important that the rates of the northern and southern California Kaiser plans be reasonable and equitable because these rates, along with the rates of four other plans, are used to compute the Government's contribution to the program. A small rate error can have a large impact on the Government's cost.

The Commission should develop criteria to evaluate Kaiser rates and determine whether they are reasonable and equitable.

HRD-78-42

JANUARY 23, 1978

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

B-164562

The Honorable Alan K. Campbell
Chairman, U.S. Civil Service Commission

Dear Mr. Campbell:

This report discusses the need for the Commission to develop criteria to evaluate Kaiser health plan rates and to make comprehensive audits of the Kaiser Foundation Health Plans of Northern and Southern California under the Federal Employees Health Benefits program.

The report contains recommendations to you on page 17. As you know, section 236 of the Legislative Reorganization Act of 1970 requires the head of a Federal agency to submit a written statement on actions taken on our recommendations to the House Committee on Government Operations and the Senate Committee on Governmental Affairs not later than 60 days after the date of the report and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

We have discussed our findings and recommendations with the Director, Bureau of Retirement, Insurance, and Occupational Health.

We are sending copies of this report to the Chairmen, House and Senate Committees on Appropriations, House Committee on Government Operations, Senate Committee on Governmental Affairs, and House Committee on Post Office and Civil Service; the Chairwoman, Subcommittee on Compensation and Employee Benefits, House Committee on Post Office and Civil Service; and the Acting Director, Office of Management and Budget.

Sincerely yours,

Gregory J. Ahart
Director

GENERAL ACCOUNTING OFFICE
REPORT TO THE CHAIRMAN,
U.S. CIVIL SERVICE COMMISSION

CIVIL SERVICE SHOULD AUDIT KAISER PLANS' PREMIUM RATES UNDER THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM TO PROTECT THE GOVERNMENT

D I G E S T

The Federal Employees Health Benefits Act requires that rates charged under health plans' contracts shall reasonably and equitably reflect the cost of benefits provided. In the case of the Kaiser health plans of northern and southern California, the Civil Service Commission has not determined whether this requirement has been met.

It is important that the Commission determine whether these two plans' rates are reasonable and equitable because they, along with the rates of four other plans, are used to calculate the Government's contribution to the Federal Employees Health Benefits program. A small rate error can have a large effect on the Government's cost.

For example, a $2 overstatement in the biweekly rate of any one of the six plans used in the calculation would have increased the Government's cost for the program by nearly $15 million for 1977. (See pp. 15 and 16.)

The Commission has made only limited audits of the Kaiser plans. Commission auditors have reported internally that:

--At one Kaiser plan their "attempt to assess the reasonableness of the * * * community rates * * * was not as detailed and independent as we would have liked." (See p. 8.)

--They questioned the reasonableness of the rate at a second Kaiser plan because they speculated that the plan was building into its community rate a significant annual surplus. (See pp. 8 and 9.)

--They questioned the equity of the rate at the Colorado Kaiser plan because Kaiser charges all groups whose contracts are renewed at varying times during the year at the same rate. The California plans also use this contract renewal system. If other factors remain equal, as long as medical costs and premium rates rise, groups whose contracts become effective later in the year are subsidized by those who pay the higher rates earlier. The Federal contract is renewed annually on January 1. (See pp. 10 to 12.)

--The financial reporting format designed by the Commission for plans such as Kaiser did not provide full financial disclosure. (See p. 13.)

The Commission auditors have not followed up on their limited audits at either California Kaiser plan. Moreover, the auditors intend to concentrate their future efforts on comprehensive plans that appear to be in financial distress. GAO believes this approach will preclude any in-depth audits of the California Kaiser plans in the near future since Commission auditors regard them as financially sound. (See pp. 13 and 14.)

One reason Commission auditors have not comprehensively audited the Kaiser plans may be that the Commission lacks criteria for evaluating the reasonableness of the Kaiser rates.

For example, unlike many Federal employee health plans and the other four plans used in calculating the Government's contribution to the program, the Kaiser plans are community-rated--premium rates are based on projected health care experience (cost and utilization) of all groups expected to be enrolled in the plan, including non-Federal enrollees.

The other four plans are experience-rated--premium rates are based only on the experience of the Federal participants. Although

community-rating is an accepted method of determining premiums, it does result in non-Federal groups affecting the amount the Government and Federal employees pay for health insurance. GAO believes that this factor makes it more difficult to determine whether the Kaiser rates are reasonable and equitable for Federal enrollees. (See p. 6.)

The Commission needs to evaluate the impact on the Federal rate of the following characteristics of the Kaiser plans:

--Experience-rated plans must apply any gains or losses to premium rates in later years. Kaiser, however, may use excess revenues as management sees fit and increase premiums to recover any losses. (See pp. 6 and 7.)

--The California Kaiser plans' rates reflect more than the cost of providing health benefits. The premuim rates are designed to meet not only current health benefit costs, but also long-term capital needs. During the 5-year period 1971-75, the Kaiser plans annually spent about $64 million, or about 9 percent of all premiums, on property, plant, and equipment. The premium rates have also included funds to help finance development of Kaiser health plans in Colorado and Ohio. (See pp. 7 and 8.)

--The Kaiser plans consistently underestimated the revenues that would be derived from the proposed premium rates presented to the Commission. For the period 1972-76, the two California Kaiser plans earned over $46 million more than estimated in their rate-making forecasts. (See p. 9.)

CONCLUSIONS AND RECOMMENDATIONS

Although the law requires that rates charged by participating plans reasonably and equitably reflect the cost of benefits provided, the Commission has not comprehensively audited the two California Kaiser plans' rates or determined their reasonableness and equity.

The Civil Service Commission should

--develop criteria to evaluate the reasonableness and equity of rates of community-rated, comprehensive health plans like the Kaiser plans and

--comprehensively audit the California Kaiser plans to determine whether their Federal Employees Health Benefits program rates reasonably and equitably reflect the cost of providing benefits to the Federal program participants. (See pp. 16 and 17.)

The audits should include an evaluation of Kaiser's practices of consistently underestimating the earnings expected to result from its premium rates; having different contract renewal dates, but the same premium rates, for different member groups; and including in its rates long-term capital needs. Additionally, the Commission should develop a financial reporting format that would disclose fully the results of operations of all components of health plans organized like Kaiser.

Contents

ABBREVIATIONS

CSC	Civil Service Commission
FEHB	Federal Employees Health Benefits
GAO	General Accounting Office

CHAPTER 1

INTRODUCTION

is report discusses the need for the Civil Service Comm ion (CSC) to develop criteria to evaluate the rates of Kaiser Foundation Health Plans of Northern California and outhern California and to conduct comprehensive audits of iese plans. Both of these plans have contracts under t Federal Employees Health Benefits (FEHB) program.

EDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

The FEHB program, established by the Federal Employees Healt.n Benefits Act of 1959 (5 U.S.C. 8901), provided health insurance coverage for 9.5 million participants (employees, annuitants, and dependents) in 1976 and 9.7 million participants in 1977. For fiscal year 1976, the FEHB program's total cost was $2.2 billion, of which the Government's share was $1.4 billion. For fiscal year 1977, program costs are expected to increase to $2.8 billion, with a Federal share of $1.7 billion; in fiscal year 1978, the program is projected to cost $3.2 billion.

CSC administers the FEHB program and contracts for coverage through the following types of health plans: (1) Service Benefit Plan (Blue Cross and Blue Shield), (2) Indemnity Benefit Plan (Aetna), (3) Employee Organization Plans, and (4) Comprehensive Medical Plans.

The Comprehensive Medical Plans, available only in certain localities, are either group practice plans providing comprehensive medical services by teams of physicians and technicians practicing in common medical centers or individual practice plans providing benefits in the form of direct payments to physicians with whom the plans have agreements. These plans also provide hospital benefits. Forty-one such plans, including 31 group practice plans like the Kaiser plans, provided benefits of about $202 million to about 760,000 program participants in 1976. In January 1977 there were 46 comprehensive plans, 35 of which were group practice plans.

Both the Government and the Federal enrollees contribute to the program's cost. The Government's contribution is computed as 60 percent of the average high-option subscription charges for six of the participating plans. Enrollees contribute the balance of the premium.

The plans used in computing the Government's contribution are the Service Benefit Plan; the Indemnity Benefit Plan; the two employee organization plans with the largest Federal enrollments; and the two prepaid, comprehensive plans with the largest Federal enrollments. The Kaiser plans of northern and southern California are the two comprehensive plans used in the calculation.

The Kaiser plans are "community-rated," while the four other plans are "experience-rated." In a community-rated plan, the premium, or community rate, is based on the anticipated experience (cost and utilization of health services) of all groups expected to be enrolled in the plan. In experience-rated plans, premiums are based only on the experience of each member group in the plan. The experience of one group does not affect the premium rate of another group in an experience-rated plan, as it does in a community-rated plan.

CSC and Kaiser contracts

Since 1960 CSC has contracted annually with the Kaiser Foundation Health Plans of Northern and Southern California to provide prepaid health care services to Federal employees. Each plan contracts separately with CSC, offering different benefits and charging different rates. CSC, through its Bureau of Retirement, Insurance, and Occupational Health, is responsible for overseeing the contracts. Specific CSC functions include

--auditing the plans to determine that the premium rates adequately reflect benefits provided,

--annually reviewing proposed benefits and negotiating contracts with the plans, and

--adjudicating disputed claims and resolving complaints between enrollees and the plans.

Kaiser health benefit program

The Kaiser-Permanente Medical Care Program (Kaiser) consists of a number of organizations that provide health care in six regions of the country. Kaiser, the largest prepaid group practice program in the United States, has been available to the public since 1945. The program provides prepaid hospital, medical, and related services to its enrollees through 26 hospitals and about 3,000 physicians. During 1975 the program reported revenues of about $750

million and membership of about 2.9 million. The northern and southern California plans accounted for 85 percent of these revenues and 84 percent of the enrollees.

In 1976 Kaiser's northern California plan covered about 155,000 FEHB program participants and received about $40 million from the program. Program participants accounted for about 12 percent of this plan's membership, and the Federal group was the largest group covered. Kaiser's southern California plan covered about 116,000 FEHB program participants and received about $36.2 million from the program. Program participants accounted for about 9 percent of this plan's membership, and the Federal group was again the largest group covered.

The participating organizations in each of the two California Kaiser plans are the (1) Kaiser Foundation Health Plan, Inc. (Health Plan), (2) Kaiser Foundation Hospitals (Hospitals), (3) Permanente Medical Group (Medical Group), and (4) Permanente Services Corporation (Services).

--Health Plan: A nonprofit corporation that contracts with individuals and groups (such as Federal employees) to arrange for comprehensive health care benefits. Health Plan also contracts with Hospitals and the Medical Group to provide the facilities and services required to meet the covered health care needs of members. Health Plan is located in three of Kaiser's regions--southern California, northern California, and Hawaii--and has subsidiaries in the three other regions--Colorado, Ohio, and Oregon.

--Hospitals: A nonprofit corporation that owns and operates general community hospitals available to both members and nonmembers.

--Medical Group: A for-profit partnership of physicians that provides medical care. The partnership receives payment from the Health Plan in the form of a per capita payment--a set amount per member per month--negotiated annually between the Health Plan and the Medical Group. Individual physicians are not paid on a fee-for-service basis. Instead, income is pooled and distributed according to a prearranged formula that does not relate income to specific services performed. The compensation arrangement includes a budgeted incentive feature in addition to the per capita payment. If the Health Plan generates more cash than the amount budgeted, the physicians receive a share of the favorable balance

as a bonus. If less funds than budgeted are generated, the budgeted incentive payment would be reduced.

--Services: A for-profit corporation that operates outpatient pharmacies and provides a variety of support services, such as data processing, accounting, purchasing, and transportation, for the other three Kaiser components. Its stock is owned entirely by the two nonprofit components--Hospitals and Health Plan. Services receives payments on a cost-reimbursable basis, plus a return on capital investment in pharmacy operations amounting to about 17.5 percent.

SCOPE OF REVIEW

We have prepared this report as a result of related work we did for the Subcommittee on Compensation and Employee Benefits, House Committee on Post Office and Civil Service, regarding reasons for the large difference in the 1976 FEHB program premium rates of the two California Kaiser plans. 1/ As part of our work for the Subcommittee, we examined CSC's role in assuring that the rates charged by the two Kaiser plans reasonably and equitably reflect the costs of the benefits provided to Federal participants.

We analyzed and evaluated CSC's administration and oversight of the FEHB program contracts with the two Kaiser plans in California. We discussed CSC and Kaiser policies and procedures with CSC officials and reviewed relevant CSC documents, studies, and reports. We also reviewed several Kaiser policies and practices that may affect the rates charged by the two plans and discussed our observations with Kaiser representatives. In addition, we reviewed relevant laws, regulations, and other documents.

We made our review at CSC headquarters in Washington, D.C., and at the Kaiser plans in the San Francisco and Los Angeles areas.

1/Our report to the Subcommittee is entitled "Reasons for Difference in Premium Rates of Kaiser Plans of Northern and Southern California for the Federal Employees Health Benefits Program" (HRD-77-151, Sept. 30, 1977).

CHAPTER 2

CSC NEEDS TO DETERMINE THE REASONABLENESS AND EQUITY OF THE CALIFORNIA KAISER PLANS' PREMIUM RATES

The Federal Employees Health Benefits Act requires that "Rates charged under health benefits plans * * * shall reasonably and equitably reflect the cost of the benefits provided." The two California Kaiser plans have been in the FEHB program since 1960. CSC, however

--has not developed criteria to evaluate the Kaiser rates and

--has never made a comprehensive audit of either plan to assess the reasonableness or equity of the premium rates.

CSC has made limited reviews of the Kaiser California plans. During these reviews, CSC has either (1) not obtained sufficient information upon which to reach a formal conclusion regarding the reasonableness of the rates or (2) raised questions in internal reports about the reasonableness of the rates. CSC, however, has not taken any formal audit exceptions to the manner in which Kaiser establishes its premium rates. This may be partly due to the fact that CSC has not developed any criteria by which to evaluate the reasonableness or equity of premium rates established by comprehensive community-rated plans such as Kaiser.

It is important that the premium rates of the California Kaiser plans reasonably and equitably reflect the costs of the benefits provided because these rates, along with others, are used to calculate the Government's contribution under the FEHB program. If these rates are incorrect, they can have a significant impact on the Government's cost. For example, a $2 overstatement in the biweekly rate of one plan would have increased the Government's costs by nearly $15 million in 1977.

We believe that CSC needs to

--develop criteria to evaluate the reasonableness and equity of the Kaiser rates and

--make comprehensive audits to determine if Kaiser rates reasonably and equitably reflect the costs of benefits provided to FEHB participants in the California plans.

NEED FOR CRITERIA TO EVALUATE AND AUDIT KAISER PLANS

CSC is the Government's representative in contracting with the various health insurance plans in the FEHB program. Besides contracting with the plans, CSC is responsible for auditing them to determine if premium rates adequately reflect the benefits provided. The FEHB Act requires CSC to make continuing studies of the FEHB plans, including surveys and reports on health benefit plans and the plans' experience. CSC, however, has never made a comprehensive audit of either Kaiser plan to assess the reasonableness or equity of the premium rates.

CSC auditors have raised questions internally about certain Kaiser practices but have not yet developed formal positions on any of these practices or their effects on rate reasonableness and equity. One reason for this lack of formal audit findings or followup may be that CSC has no criteria by which to evaluate the reasonableness of the Kaiser plans' (or other comprehensive plans') community rates within the context of the FEHB Act. The following describes certain practices for which we believe CSC should develop evaluation criteria.

An important difference between the two Kaiser plans and the other four plans used in calculating the Government contribution is that the Kaiser plans are community-rated--premium rates are based on projected health care experience (cost and utilization) of all groups expected to be enrolled in that plan, including non-Federal enrollees. The other four plans are experience-rated--premium rates are based only on the experience of the Federal participants. Community-rating is an accepted method of arriving at premiums and is required by the Health Maintenance Organization Act of 1973 (42 U.S.C. 300e). In the case of the FEHB program, community-rating means that other groups affect the amount that the Government and Federal enrollees pay for their health insurance. We believe this factor makes it more difficult to determine whether the Kaiser rates are reasonable and equitable for Federal enrollees.

Another difference between the two types of plans is the use of any financial gain or loss from the results of operations each year. The experience-rated plans apply gains or losses to premium rates in the next contract year--gains are used to reduce rates or lessen increases, and losses are made up through increased rates. Kaiser and other community-rated plans, however, are not required to

apply gains or losses in later years. According to a CSC official, excess revenues may be used in any manner Kaiser management chooses. However, should a loss occur, Kaiser would probably recoup the loss by increasing future years' premiums.

The rates of Kaiser's two California plans reflect more than just the cost of providing health care during a given year. The northern and southern California plans set their premium rates annually using complex budgeting techniques designed to provide enough funds to meet both current operating requirements and long-term capital needs.

Kaiser develops a plan spanning at least 5 years to project its long-term needs and uses the plan to compute its annual premium rates. This plan addresses such factors as projected membership growth and the need for new and replacement facilities. Kaiser spent an average of about $64 million each year from 1971 to 1975 for property, plant, and equipment. Thus, the annually established rates reflected more than the expected cost of providing health care for 1 year. During the 5-year period about 9 percent of the premiums represented costs and earnings necessary to finance Kaiser's building and expansion program.

Health insurance plans generally finance their costs through subscription income, and in this sense Kaiser is no different from Blue Cross and Blue Shield and Aetna. The contracts between CSC and Blue Cross and Blue Shield and Aetna, however, limit the amount of subscription income that can be spent on items other than current health benefits. Blue Cross and Blue Shield's 1977 administrative expense limitation was 5.0 percent of subscription income; Aetna's was 4.5 percent. These limitations include the cost of processing insurance claim forms. The Kaiser contracts with CSC, however, do not limit the administrative cost or the premiums to be allocated for capital needs. CSC has no criteria to evaluate the reasonableness of the expenditures that are not directly related to current health care and that are included in Kaiser's Federal group rates.

For example, from 1969 through 1974, the Kaiser rates for the two California plans included budgeted contributions to an expansion fund designed to help finance development of Kaiser plans in Colorado and Ohio. The fund was discontinued at the end of 1974 because, according to the Kaiser controller, the Colorado and Ohio plans had become financially stable. While the fund existed, the Kaiser plans of northern California, southern California, Hawaii, and Oregon together

contributed $7.6 million, based on each plan's proportion of the four plans' total membership. The northern and southern California plans' share was $6.2 million.

Both California plans included the expansion fund in their "costs and capital requirements" in the ratemaking budgets. CSC did not determine whether this transfer of funds was legal under the FEHB Act and has no formal position on the practice.

CSC AUDITS OF KAISER PLANS

CSC established a comprehensive prepaid group practice plan audit team in 1974, when an increasing number of such plans began entering the program. CSC has considered the initial audits of comprehensive group practice plans to be informational, "get acquainted" reviews, and no formal CSC audit reports have been issued. As of October 1, 1977, CSC had completed limited reviews of 24 of the 35 comprehensive group practice plans that were participating in the FEHB program at the beginning of 1977.

The following sections discuss issues raised by CSC auditors in their limited reviews of Kaiser plans. Also included is information that we developed in conjunction with our analysis of the difference between the 1976 rates of the northern and southern California Kaiser plans.

Reasonableness of rates

CSC made limited reviews of the northern California and southern California plans in 1974 and 1976, respectively. The auditors characterized the review at one plan as "broad-brush." They were unable to obtain much of the information they had sought or to verify independently some of the information they received relating to the community rates. The auditors concluded "* * * our attempt to assess the reasonableness of the * * * community rates * * * was not as detailed and independent as we would have liked."

At the other plan, the auditors' internal report questioned the reasonableness of Kaiser's premium rate because it was as high as the rates of the smaller group practice plans in the same geographical area. Since the Kaiser plan (1) had about 10 times as many members as the second largest group practice plan in the area and (2) the CSC auditors believed Kaiser had well-designed and efficient cost controls, the auditors had expected economies of scale to result in relatively lower costs and premiums for the Kaiser plan.

The auditors speculated that, instead of passing on to its members the lower costs that should have resulted from economies of scale, the plan had built into its community rate a significant annual surplus. The auditors further stated that

--almost all of this surplus was eventually distributed to Kaiser's Hospitals and Medical Group;

--Kaiser would have little incentive to reduce its premium rates below those of its competitors as long as it was able to enroll as many members as its medical system could absorb; and

--this plan's record substantiated that there were significant limitations to the widely claimed economy incentive of group practice plans (i.e., that a fixed premium provides an incentive to keep medical costs and, by inference, premium rates, at a minimum).

As a result of this limited audit, CSC told the plan that "questions still remain about the causes of the exceptional increases which have been occurring in Kaiser * * * FEHBP premium rates." CSC, however, did not give the plan details of potential findings contained in its internal document.

As part of our analysis of the rate differences of the two California plans, we compared the actual operating results with the ratemaking forecasts for 1972-76 at each plan. The comparison showed that revenue forecasts were consistently understated at both plans and that one plan overstated expense forecasts for 2 years. The net results of financial operations always varied from the forecasts and, in 9 of 10 instances, in a direction favorable to Kaiser. For 1972-76, Kaiser's northern California plan had a net favorable variation from the forecasts of $13.7 million and its southern California plan had a net favorable variation of $32.4 million. (See apps. I and II.) These variations were not large compared to the two plans' total budgets. We believe, however, that the generally consistent variation in a direction favorable to Kaiser points up a need for CSC to gain a full understanding of Kaiser's ratemaking processes in order to determine whether the rates reasonably and equitably reflect the costs of the benefits provided.

Equity of rates

CSC auditors have also questioned the equity of Kaiser's rates. Kaiser begins to apply its community rate increases on January 1 of each year. The new rates become effective on the renewal date of each group's contract. The Federal group contract is renewed on January 1, but some other groups' contracts are renewed later in the year. If other factors remain equal, as long as medical costs and premiums rise, groups whose contracts become effective later in the year are subsidized by those groups who pay the higher rates earlier.

According to CSC officials, other well-established community-rated plans adjust rates for contracts beginning after January 1 through various methods. For example, if a rate was $20 a month, all groups whose contracts started on January 1 would pay that rate. Rates for groups whose contracts began later would include an adjustment to compensate for the later starting date. For example, if the necessary adjustment was determined to be 10 cents a month for every month after January 1 and if a group's contract began on July 1, that group's monthly premium rate would be $20.60 during the 1-year contract period.

During preparations for the 1973 contract, CSC noted that Kaiser did not adjust its rates for groups whose contracts began after January 1. CSC requested Kaiser to raise its rates for those groups in an effort to produce more rate equity. Kaiser declined to make the adjustment, saying that its method of applying rates was equitable and that the system was simple to administer. Kaiser suggested that, if all costs were computed, it might turn out that the Federal group was being subsidized by other groups. Kaiser officials suggested that "the Federal Group's postpayment practice [CSC pays premiums to Kaiser after the effective coverage period], additional statistical data requirements, special administrative requirements, and the long lead time for the Federal group in requiring rates and benefits" strongly suggested that other member groups were subsidizing the Federal group.

CSC accepted Kaiser's method of applying its rate increases for the 1973 contract but asked Kaiser for additional information so that the matter of setting rates could be resolved for the 1974 contract period. According to CSC estimates, had Kaiser accepted the CSC proposal for the 1973 contract, Federal enrollees in the Kaiser plans would have saved $987,000 and the Government would have saved $658,000 due to lower premiums in 1973. Additionally, CSC estimated

that, because two of the Kaiser plans are included in the six plans that determine the Government contribution, lower Kaiser rates would also shift some of the overall costs from the Government to enrollees in all FEHB plans. For 1973 the shift in cost would have been about $6 million. 1/

For 1974 CSC proposed to Kaiser a method for establishing a basic community rate each year and adjusting contract rates for groups starting February 1 or later. CSC told Kaiser that it had "not found any other carriers who do not achieve equity by adjusting the rates for our contract when the time period of the general community is other than the calendar year."

Kaiser rejected this CSC proposal also and repeated that its method was equitable. Kaiser said that evaluating its methods solely in terms of calendar year payments was not valid. Kaiser also suggested that it might not participate in the FEHB program if CSC did not agree to accept Kaiser's traditional method of applying community rate increases. CSC decided to permit Kaiser to continue to use its traditional method.

Part of a 1976 CSC limited review of the Kaiser Colorado plan involved analyzing varying contract renewal dates and their effect on the plan's proposed rates. 2/ CSC estimated that at this plan (with a July 1976 Federal participation of 14,918, compared to 270,811 for the two California plans)

1/This $6 million savings estimate for the Government was for a year when the program's total cost was about $1.. billion and the Government's contribution was based on a 40-percent factor. Making a straight-line interpolation to fiscal year 1977--for which the program cost is estimated at $2.8 billion and the Government contribution is based on a 60-percent factor--yields an estimated savings to the Government of $18 million.

2/CSC auditors have not raised the question of contract renewal dates with plans other than Kaiser because either (1) the problem does not exist, (2) there would be a very small dollar impact because few Federal employees are enrolled or the percentage of people in the groups starting after January 1 is small, or (3) the auditors are waiting to see how CSC resolves the issue with Kaiser because of the large amount of money and Federal enrollees involved with Kaiser's six plans.

"all contracts renewing on January 1 are subsidizing contracts not renewing on January 1 by a total of $246,800." The FEHB program's estimated share of this misallocation was about $51,403. The effect was to increase the proposed monthly Federal family rate in the Colorado plan by $1.02. CSC said that if all contracts were renewed on January 1 and all rates were increased equally, the Colorado plan's community rate increase for 1977 would have been 16.7 percent instead of 18.3 percent.

Kaiser told CSC it received premium income from the FEHB program about 45 days after the beginning of the pay period during which an enrollee was covered. If any of the FEHB plans normally collect premiums in advance, CSC allows the plan to increase its premium by 0.9 percent to compensate for any interest lost due to CSC's delayed payment. This 0.9-percent factor is based on an assumed earnings potential of 7 percent and a 45-day payment lag. Kaiser, however, does not add this interest to its premium. 1/ In the Kaiser Colorado plan, CSC found that the payment delay was 32 days. Using this delay period and computing the interest at 9 percent, 2/ CSC estimated that the Kaiser Colorado plan could have lost interest amounting to $34,650 in 1977.

Although the Colorado plan has a small Federal participation, the net result of CSC's study at the Colorado plan was that the FEHB program would overpay almost $17,000 in 1977. Although CSC auditors have again raised this issue, CSC has not taken any action because the Commissioners had previously allowed Kaiser to use its established rate throughout the year without any adjustments.

1/In 1975 Kaiser's California plans had formally requested a contract amendment to allow a loading factor to reflect the loss of interest due to delayed payment. CSC responded that such an amendment would probably have to be based on a complete review of the Kaiser rate structure. This would, according to CSC, have also included a review of the impact of varying renewal dates for member groups' contracts. Kaiser informally withdrew its request.

2/CSC auditors told us they had used a liberal 9-percent factor to arrive at a conservative estimate of the net savings to the FEHB program.

Need for better financial reporting

CSC requires the FEHB plans to submit annual accounting statements. The format CSC initially required for these statements was primarily designed to show the financial results of an experience-rated health plan like the Service Benefit Plan, rather than community-rated plans like Kaiser.

The Kaiser plans' annual accounting statements submitted to CSC did not present the total financial results of all the plans' separate organizational components. CSC auditors noted this problem during a limited audit of one Kaiser plan. The annual accounting statements Kaiser had provided to CSC presented only the results of Health Plan, the organizational component that contracts with CSC, collects membership dues, and contracts with Hospitals, Medical Group, and Services (the other Kaiser organizational components) for health care and support services. The net incomes of these other components are simply shown as an expense on Health Plan's annual accounting statement. For example, the southern California plan's 1975 calendar year accounting statement submitted to CSC reported a $766,984 excess of revenue over expenses. When the four Kaiser organizational components' incomes are combined, however, there was a $12,512,592 excess of revenue over expenses.

CSC changed the 1977 calendar year accounting statement reporting format for community-rated group practice plans, but the change will not overcome the disclosure problem noted above. The new format still will not show the profits of Medical Group or Services or the net income of Hospitals. These items remain simply as expense items on Health Plan's financial accounting statement.

CSC plans to use this revised accounting statement in deciding which plans are in financial distress and should receive future audit attention. In view of the still inadequate disclosure, however, CSC's choices for audit will be based on criteria that may not truly indicate the plan's financial position.

Lack of audit followup

CSC has not followed up on its limited audits at any of the Kaiser plans. Additionally, it has not scheduled comprehensive reviews for either California Kaiser plan. CSC said reviews at plans in financial distress will be scheduled before Kaiser is audited again.

According to CSC, one factor that will affect future CSC audits of FEHB prepaid group practice plans is the recent growth in the numbers of these plans. The FEHB program had 19 group practice plans in 1974, 25 in 1975, 31 in 1976, and 35 at the beginning of 1977. The number of prepaid group practice plans has increased since passage of the Health Maintenance Organization Act of 1973 (42 U.S.C. 300e), which provided for the development of such plans with aid and financial assistance from the Department of Health, Education, and Welfare.

CSC told us that in July 1977 it had abolished its plans to audit each group practice plan every 3 years. Instead, CSC will audit those plans with financial problems, based on its review of the accounting statements these plans are required to submit. This approach, we believe, will preclude any in-depth audits of the northern and southern California Kaiser plans in the near future since CSC believes that these plans are financially stable.

KAISER PLANS AND THE GOVERNMENT'S COST CALCULATION

The Government's contribution for health insurance premiums is based on the average of six FEHB plans' premium rates. Public Law 93-246 (5 U.S.C. 8906) sets the Government contribution for health benefits at 60 percent of the "average of the subscription charges in effect on the beginning date of each contract year * * * for the highest level of benefits offered by

(1) the service benefit plan;

(2) the indemnity benefit plan;

(3) the two employee organization plans with the largest number of enrollments, as determined by the Commission; and

(4) the two comprehensive medical plans with the largest number of enrollments, as determined by the Commission."

The act also states that the Government's contribution "shall not exceed 75 percent of the subscription charge."

Since the two Kaiser plans in California have the largest enrollments of the FEHB comprehensive plans, their premiums are used in determining the Government contribution. Because

the Government's contribution is based on a simple average, each of the six plans, regardless of enrollment, has an equal effect in determining the Government's share. For example, Kaiser's southern California plan, with a Federal enrollment of 40,000 in 1976, had the same effect on the Government's contribution as the Service Benefit Plan, which had a Federal enrollment of almost 2 million.

It is important that rates charged by the six plans used in computing the Government contribution to the program reasonably and equitably reflect the cost of benefits provided because (1) this was clearly the intent of the Congress and (2) the Government contribution is very sensitive even to small overstatements or understatements of the rates. The following table and calculations show how the Government contribution for calendar year 1977 would be computed according to the act and how a $2 overstatement by one of the six carriers would increase the Government's cost by $14.8 million during the year in which the rates were effective.

Computation of 1977
Standard Government Contribution

Plan	Total biweekly high-option family premium	Total biweekly high-option self-only premium
Service Benefit Plan	$ 46.11	$19.45
Indemnity Benefit Plan	36.54	16.13
National Association of Letter Carriers	39.95	15.28
American Postal Workers Union	41.25	16.86
Kaiser-northern California	37.84	14.72
Kaiser-southern California	44.20	17.12
Total	$245.89	$99.56

1977 biweekly standard Government contributions:

Family option: $245.89 ÷ 6 = $40.98 X 60% = $24.59

Self-only option: $99.56 ÷ 6 = $16.59 X 60% = $9.95

If any one plan's 1977 premium had been lower by $2 biweekly, the following revised computation of the biweekly standard Government contribution would result:

Family option: $243.89 ÷ 6 = $40.65 X 60% = $24.39

Self-only option: $97.56 ÷ 6 = $16.26 X 60% = $9.76

Thus, had any plan's biweekly premium been overstated by $2, the biweekly standard Government contribution would have been overstated by 20 cents for the family option and by 19 cents for a self-only option.

The estimated cost to the Government of a $2 overstatement would be as follows:

Overstated cost per pay period		Pay periods per year		Government's annual overstated cost per enrollee	High-option enrollment (note a) Family	Self	Estimated annual overstated cost to the Government
					(millions)		
$0.20	X	26	=	$5.20	X 2.0		= $10.4
.19	X	26	=	4.94	X	0.9	= 4.4
							$14.8

a/In this example, there would be no effect on the Government contribution for the approximately 400,000 low-option enrollees since the maximum Government low-option contribution is less than the Government's contribution in both cases shown above.

CONCLUSIONS

Although (1) the FEHB Act requires that rates charged by plans participating in the program reflect reasonably and equitably the cost of benefits provided and (2) the two California Kaiser plans' rates are used in computing the Government's contribution to the FEHB program, CSC has not audited the Kaiser plans comprehensively or determined the reasonableness and equity of these two plans' rates.

In view of (1) the FEHB Act's requirement that rates charged under the FEHB program reasonably and equitably reflect the cost of benefits provided, (2) the lack of comprehensive CSC audits of the California Kaiser plans, and (3) the impact that the California Kaiser plans' rates have on the Government's cost, CSC needs to develop criteria to evaluate the reasonableness and equity of rates of community-rated plans and comprehensively audit the California Kaiser plans.

We believe such audits should include an evaluation of Kaiser's practices of (1) consistently underestimating the earnings expected to result from its premium rates, (2) having different contract renewal dates, but the same premium rates, for different member groups, and (3) including in its rates long-term capital needs. Additionally, CSC, perhaps as a result of its audits, should develop a financial reporting format for FEHB community-rated health plans that would disclose fully the results of operations of all components of health plans organized like the Kaiser plans.

RECOMMENDATIONS TO THE CHAIRMAN, CSC

We recommend that the Chairman have CSC

--develop criteria to evaluate the reasonableness and equity of rates of community-rated, comprehensive health plans like the Kaiser plans and

--comprehensively audit the California Kaiser plans to determine whether their FEHB program rates reasonably and equitably reflect the cost of providing benefits to FEHB participants.

APPENDIX I

SUMMARY: RATEMAKING FORECASTS COMPARED TO ACTUAL RESULTS OF OPERATION, 1972-76

Southern California Plan

	Forecast (note a)	Actual	Favorable or unfavorable (-) variance from forecast
	(000 omitted)		
1972:			
Total revenues	$193,260	$198,943	$5,683
Total expenses	184,983	189,315	-4,332
Net income	$ 8,277	9,628	$1,351
Less carry-forward to future years (note b)		3,252	
Adjusted net income		$ 6,376	
1973:			
Revenues	$226,138	$227,416	
Carry-forward from prior years (note b)	800	3,252	
Total revenues	226,938	230,668	$3,730
Total expenses	217,112	221,728	-4,616
Net income	$ 9,826	8,940	$ -886
Less carry-forward to future years (note b)		1,481	
Adjusted net income		$7,459	
1974:			
Revenues	$271,623	$274,588	
Carry-forward from prior years (note b)	0	1,481	
Total revenues	271,623	276,069	$4,446
Total expenses	260,153	256,031	4,122
Net income	$ 11,470	20,038	$8,568
Less carry-forward to future years (note b)		6,924	
Adjusted net income		$ 13,114	

APPENDIX I

	Forecast (note a)	Actual	Favorable or unfavorable (-) variance from forecast
	(000 omitted)		
1975:			
Revenues	$324,140	$323,711	
Carry-forward from prior years (note b)	0	6,924	
Total revenues	324,140	330,635	$6,495
Total expenses	311,106	310,723	383
Net income	$ 13,034	19,912	$6,878
Less carry-forward to future years		7,399	
Adjusted net income		$ 12,513	
1976:			
Revenues	$380,199	$396,754	
Carry-forward from prior years (note b)	6,000	7,399	
Total revenues	386,199	404,153	$17,954
Total expenses	372,801	374,227	-1,426
Net income	$ 13,398	29,926	$16,528
Less carry-forward to future years		6,174	
Adjusted net income		$ 23,752	
Net favorable variance			$32,439

Note: Kaiser said it used $4,241,000 of the $6,174,000 1976 carry-forward in the 1977 ratemaking budget.

(Notes a and b appear on pp. 21 and 22.)

APPENDIX II

SUMMARY: RATEMAKING FORECASTS COMPARED TO ACTUAL RESULTS OF OPERATION, 1972-76

Northern California Plan

	Forecast (note a)	Actual	Favorable or unfavorable (-) variance from forecast
	(000 omitted)		
1972:			
Total revenues	$194,124	$201,598	$7,474
Total expenses	186,799	189,871	-3,072
Net income	$ 7,325	11,727	$4,402
Less carry-forward to future years (note b)		4,165	
Adjusted net income		$ 7,562	
1973:			
Total revenues	$225,145	$233,961	$8,816
Total expenses	216,688	223,015	-6,327
Net income	$ 8,457	10,946	$2,489
Less carry-forward to future years (note b)		2,033	
Adjusted net income		$ 8,913	
1974:			
Revenues	$253,893	$263,180	
Carry-forward from prior years (note b)	4,165	4,165	
Total revenues	258,058	267,345	$9,287
Total expenses	248,367	255,399	-7,032
Net income	$ 9,691	11,946	$2,255
Less carry-forward to future years (note b)		1,986	
Adjusted net income		$ 9,960	

APPENDIX II

	Forecast (note a)	Actual	Favorable or unfavorable (-) variance from forecast
	(000 omitted)		
1975:			
Revenues	$293,960	$308,795	
Carry-forward from prior years (note b)	5,476	4,019	
Total revenues	299,436	312,814	$13,378
Total expenses	287,848	300,278	-12,430
Net income	$ 11,588	$ 12,536	$ 948
1976:			
Total revenues	$356,714	$369,117	$12,403
Total expenses	344,570	353,356	-8,786
Net income	$ 12,144	$ 15,761	$ 3,617
Net favorable variance			$13,711

a/Ratemaking forecasts are prepared during the year preceding the calendar year in which rates go into effect.

b/From 1972 through part of 1974, when the Economic Stabilization Program limited hospital earnings to predetermined amounts, both of the California Kaiser plans forwarded earnings in excess of Program limitations into future years. The southern California plan continues to forward earnings but the northern California plan ceased this practice in 1975.

The northern California plan used all $8.2 million of its actual forwarded earnings to reduce future years' premium rates. The southern California plan, from 1972 through 1976, used about 44 percent ($11 million) of its forwarded earnings to reduce future premium rates, including the rates for calendar year 1977 (see note on p. 19). The other 56 percent ($14.2 million), according to Kaiser officials, was used in the plan's operating budgets to provide additional services to its members or was applied to unanticipated costs.

APPENDIX II

For 1974 and 1975, neither the carry-forward policy, the amounts involved, nor the effects thereof on financial results could be determined by reading the financial reports and accompanying footnotes certified by Kaiser's independent accountants. Kaiser officials said that notes to the 1976 statement would be used to identify the carry-forward policy.

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